DMA-460: 06-EOMB

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DEPARTMENT OF COMMUNITY HEALTH - DIVISION OF MEDICAL ASSISTANCE MEDICARE NOTIFICATION FORM

| nese services are not covered by Medicare Part A, Medicare Part B, or the Medicare HMO in which this member is enrolled. Medicare Part A was terminated on | lember Name: | Medicaid ID #: | |
|--|--|--|--|
| MEDICARE NON-COVERAGE AFFIDAVIT These services are not covered by Medicare Part A, Medicare Part B, or the Medicare HMO in which this member is enrolled. Medicare Part A was terminated on Medicare Part B was terminated on Date Service is non-covered by Medicare; Annual/lifetime service limits exceeded; and/or Other (explain) y signing, I certify that, to the best of my knowledge, the information above is verified and accurate, and that this otification form applies to any associated claim(s) and is made a part thereof. Signature of Patient Account Representative Date Provider # ote: This statement must be in accordance with the provisions of Part I, Policies and Procedures, Chapter 200 - Timely Submission, ection 202.2(b). Attach this form to your claim(s) for paper claim submission, or if claim submitted electronically, indicate the associated TCN above and forward to GHP for processing. MEDICAP/MEDICARE SUPPLEMENTAL INSURANCE INFORMATION UPDATE then a provider has knowledge that a member is enrolled in any other insurance or health benefit plan, other than Medicare and Medicaid, you a sligated to notify the Department of that coverage. You can do so by completing only this portion of the form. It may be faxed to GHP ATTN: COB Unit. PO Box 3000, McRes, GA 31055; there are multiple cards, e.g., a medical card an armaey card, complete separate forms or make copies of all cards (front & back) to submit with this form. COORDINATION OF BENEFITS (COB) INFORMATION: Please complete in full or attach a copy of the insurance card(s), front and back. Policyholder: Pl. Relationship to Policyholder: Policy #: Employer: Group #: Subscriber/Member ID #: Effective Date: Coverage Type(s): (Circle all that apply) Medicare Part A Supplement Medicare Part B Supplement Pharmacy Long Term Care Dental Vision | MEDICARE CO-PAYMENT N | OTIFICATION | |
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| Medicare Part A was terminated on | . MEDICARE NON-COVERAGE | E AFFIDAVIT | |
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| Coverage Type(s): (Circle all that apply) Medicare Part A Supplement Pharmacy Long Term Care Dental Vision | | • | |
| Coverage Type(s): (Circle all that apply) Medicare Part A Supplement Pharmacy Long Term Care Dental Vision | Subscriber/Member ID #: | Effective Date: | |
| Other: | Coverage Type(s): (Circle all that apply) | | |
| | Other: | | |